(X6) DATE

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
000162				B. WING		09/24/2012	
NAME OF PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		-
WILLIAMSBURG HEALTH & REHAB			1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
K 000	000 INITIAL COMMENTS			K 000			
	A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.						
	Survey Date: 09/24/12						
	Facility Number: 000162 Provider Number: 155261 AIM Number: 100284300						
	Surveyor: Dennis Austill, Life Safety Code Supervisor						
	At this Quality Assurance Walk-thru survey, Williamsburg Health & Rehabilitation was found in compliance with 410 IAC 16.2-3.1-19(ff)						
	This one story facility was determined to be of Type II (111) construction and was fully sprinklered The facility has a fire alarm system with smoke detection in the corridors and areas not separated from the corridor. The facility has battery operated smoke detectors in 58 resident rooms. The facility has a capacity of 116 and had a census of 74 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and in compliance in regard to smoke detector coverage.						
	access were sprinkler	esident have customary red. The facility has two parns used for storage. prinklered.	О				
		bert Booher, Life Safet cal Surveyor on 09/26/					
ndiana Ctata I	Department of Health						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 6899 ELYJ21 If continuation sheet 1 of 1

TITLE